Information Exchange Provider Directory Task Force
Draft Transcript
October 25, 2010

Presentation

Judy Sparrow – Office of the National Coordinator – Executive Director
Good morning, everybody, and welcome to the HIT Policy Committee's Information Exchange Workgroup. This is a federal advisory committee, so there will be opportunity at the end of the meeting for the public to make comment. Just a reminder for workgroup members to please identify yourselves when speaking.

Let me do a quick roll call. Micky Tripathi?

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
Here.

Judy Sparrow – Office of the National Coordinator – Executive Director
Judy Faulkner?

Carl Dvorak – Epic Systems – EVP
Carl Dvorak here for her.

Judy Sparrow – Office of the National Coordinator – Executive Director
Connie Delaney? Gayle Harrell? Michael Klag? Deven McGraw? Latanya Sweeney? Charles Kennedy? Paul Egerman?

Paul Egerman – Software Entrepreneur
Here.

Judy Sparrow – Office of the National Coordinator – Executive Director
Jim Golden?

James Golden – Minnesota Dept. of Health – Director of Health Policy Division
Here.

Judy Sparrow – Office of the National Coordinator – Executive Director
Dave Goetz?

Dave Goetz – State of Tennessee – Commissioner, Dept. Finance & Admin.
Here.

Judy Sparrow – Office of the National Coordinator – Executive Director
Jonah Frohlich?

Jonah Frohlich – HIT at California HHS Agency – Deputy Secretary
Here.

Judy Sparrow – Office of the National Coordinator – Executive Director
Steve Stack?

Steven Stack – St. Joseph Hospital East – Chair, ER Dept

Here.

Judy Sparrow – Office of the National Coordinator – Executive Director
George Hripcsak? Seth Foldy? Jim Buehler? Walter Suarez?

Walter Suarez – Institute HIPAA/HIT Education & Research – Pres. & CEO
Yes, I'm here.

Judy Sparrow – Office of the National Coordinator – Executive Director
David Roth? Hunt Blair? George Oestreich? Donna Frescatore? Jessica Kahn? Tim Andrews?

Tim Andrews
Here.

Judy Sparrow – Office of the National Coordinator – Executive Director
Sorin Davis?

Sorin Davis – CAQH – Managing Director, Universal Provider Data Source (UPD)
Here.

Judy Sparrow – Office of the National Coordinator – Executive Director
Sid Thornton?

Sid Thornton – Intermountain Healthcare – Senior Medical Informaticist
Here.

Judy Sparrow – Office of the National Coordinator – Executive Director
JP Little? Did I leave anyone off?

Art Davidson – Public Health Informatics at Denver Public Health – Director
This is Art Davidson.

Judy Sparrow – Office of the National Coordinator – Executive Director
I'll turn it over to Micky.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
Thanks, everyone, of the Directory Taskforce for joining today. We've reported out to the HIT Policy Committee last week, and would now like to move forward with the real work on the recommendations that we have proposed over the next couple of months. We've got Jonah Frohlich and Walter Suarez, the co-chairs of our provider Directory Taskforce on the phone as well.

What we wanted to cover today is, we've got the agenda here, for those of you who are able to observe it on the WebEx. I think what we wanted to be able to do is review the HIT Policy Committee meeting and the consensus principles, so a little bit of debrief on the meaning itself, what we heard in the way of feedback from a few members of the Policy Committee, what that says about direction going forward. I don't think that there's any real change in direction based on the comments that we had. Then wanted to remind ourselves and confirm the consensus principles that we presented at that meeting.

Then I think what we want to start doing is dive into the entity directories conversation, which is the round one of the sort of staged recommendations that we're going to be making over the next couple of months. Now is the sort of real roll up the sleeves work of being able to move from those principles to a focused conversation about the different types of directories that we'd want to make some recommendations on. We have a proposed framework for walking through that, which is essentially a proposal for our work going forward, as a work plan.

Then we're hoping to have a conversation about terminology and definitions, which is always a complicated conversation, but I think it's important for us now to try to nail down some of these terms and definitions so that we're using common language and have common understanding of the different key terms that we're going to use, as we go forward. Importantly and critically, making sure that we are using terms that are consistent with certainly kind of framework documents that are already out there, as well as terms that are being used by other workgroups like the Privacy and Security Tiger Team, the certification workgroup, the Standards Committee at large, and the Policy Committee at large.

Then, finally, wanted to and hopefully—we may not be able to get to all of this in this call, but start to have a discussion of users and uses, which is sort of the first step in the proposed framework that we'll be seeing. To the extent that the workgroup and the taskforce feels comfortable with the framework, it would essentially be saying, now let's dive into the first step of the framework, which is to say, how do we define who the users and uses—who the users would be, target users or priority users of an entity type directory, who they would be, and what uses we think we need to focus on in our deliberations.

If that feels like a good agenda and, certainly, a healthy agenda for the time that we have, I would suggest that we move to the next slide. This is just a presentation of the principles that we presented at the HIT Policy Committee meeting. I won't go down each one, but would just sort of say that we've got two levels that proposed. Hopefully everybody remembers these as ones that we had come to an agreement on. Then maybe I'll ask Jonah to make any comments based on his. I think, Jonah, you were able to listen in, I think, on the whole Policy Committee meeting as well, and Walter, and would love to get your sense of that as well.

But what we did is we divided the principles up into two categories. One is what initial principles should apply generally to provider directories. We know that as we dig further into this, there will be a set of principles that will be more specific to what it is we're talking about, but in our conversations up until now, we did, I think, glean these as a set of principles that, even at this level, we could say would apply to any concept of provider directories that we wanted to be weighing in on. These are the openness and transparency collection, use, and disclosure limitation, data quality integrity, safeguards, and accountability.

Then we had a set of principles that were kind of more internally focused about what principles should we as a taskforce, as a workgroup use in our deliberations as sort of the core set of principles that would apply to our recommendations. You can see what those are. There again, hopefully these are all familiar to everyone since I think we agreed to these. We walked through these at the Policy Committee meeting. There were three types of comments that I remember getting are three specific comments.

I don't know if Deven McGraw is on the phone, but Deven had a question or a comment that I think really relates to a little bit later in sort of the framework here about who would, for any of the recommendations that we make, who do we have the authority to make those recommendations to? What organizations, entities would these recommendations actually apply to? What's sort of the policy framework for thinking about that? That was, generally, I think, the question that Deven had. I think, as we discussed, that's a further consideration that we know is on the agenda here, but not one that we were able to specifically say right now what that is. It's a part of our deliberations.

Latanya Sweeney had a question about whether we were too focused on a particular network architecture or a particular paradigm when she was looking at the schematic that we had put up. My response to her was that if we had somehow communicated through that or through any other means, that we were focused on a particular technology or a particular architecture that we were absolutely not. That any recommendations we wanted to make are technology and architecture neutral or independent. Obviously there's going to be a tension there about how detailed you can get when you're trying to stay at a level above that, but that was the other comment that I think came.

I thought there was one other comment that someone had, and I can't really remember it. Maybe I'll ask Jonah and Walter for their perceptions and perspectives from the meeting.

Jonah Frohlich – HIT at California HHS Agency – Deputy Secretary
I thought the recommendations for our principles were well received. I think Latanya's comment is one that we obviously have to consider seriously because her concern was that we had a preconceived idea of what a directory or a set of directories looked like. I think we spent, as a group, a lot of time trying not to have a vision of what the directories, the kind of architecture for the directories should be. But I do think we need to continually check ourselves, as we make recommendations, because we can very easily, and I think, at times we did kind of fall into a trap. I think her point was very well taken, and we just need to be very cautious. We just need to check ourselves.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
Walter, do you have any?

Walter Suarez – Institute HIPAA/HIT Education & Research – Pres. & CEO
No, I think you summarized it very well. I don't know if you mentioned. I'm trying to remember exactly the comment that I think at the end David Lansky made regarding, and this maybe has to do with what Deven was talking about, which was the concept of whether this is open participation, volunteered participation. How the whole process really becomes sort of the guiding process for the industry, the required process, the required approach, etc. I think that was part of Deven's comments too.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
I think that's right. I guess I kind of think of that as being a part of what is the it that we have to get to.

Art Davidson – Public Health Informatics at Denver Public Health – Director
I had a comment during the committee meeting I just wanted to bring back. The way that these are worded right now, it's focused on the health information exchange. I wondered if these—data, quality, integrity—relate more to the provider directory or to the health information exchange, the same thing for collection, use, and disclosure limitation. The way that I read this now, it seems like it's more serving health information exchange, but are there issues around collection, use, disclosure, data, quality, integrity, specific to the provider directories?

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
I can take that. These are ….

Paul Egerman – Software Entrepreneur
I barely heard Art. Could you repeat the question?

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
Sure. The question was, Art, in looking at both of these sets of principles, is feeling that these seem to apply to the health information exchange. Art, I'm just using the exact words you used, which suggest the noun, like a health information exchange organization. Or did you mean more generally to health information exchange and not specifically to provider directories?

Walter Suarez – Institute HIPAA/HIT Education & Research – Pres. & CEO
Yes. Maybe to clarify the point, I think what we tried to do when we were drawing the parallel between the regional four or five core principles of nationwide information network, we were trying to figure out how do the provider directories support and use the same principles in defining the exchanges themselves. To your point, Art, I think there is a collection, use, and disclosure element with respect to the data that populates the provider directories, which is, I think, what you're maybe asking about is really there is certainly a parallel element around how the provider directories themselves, the content of the data, the information about a provider organization, entity, or individual provider gets collected, used, disclosed. What's the data quality and integrity of that data itself?

Yes, there are those two probably important, I mean, they are clearly important perspectives. We were trying to draw more of a parallel between this or create a connection between these principles and how the provider directories support them in the context of an information exchange. But again, I think the point is made to make sure that we also consider these principles in the context of the data that these provider directories will collect, use, disclose.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
But I think that in agreeing to these, we were saying that these five principles apply to the directory themselves. Now it raises the Deven/David Lansky question of, which directories and by what authority? But, Art, to your question, for example, when it says collection, use, and disclosure limitations, it's saying, and please anyone correct me if you have a different interpretation of this, what's this saying is that for the information that is in the provider directory, so let's say you're a provider and your information is in the directory, that you understand what the collection, use, and disclosure limitations are of the information related to you that is in that directory.

Walter Suarez – Institute HIPAA/HIT Education & Research – Pres. & CEO
Well, it is both aspects that we have to handle. In the way it is worded right now, and that is why in parentheses you see collection and disclosure. You don't see use in there because, in the way we worded it, we were primarily focusing on the information exchange support that provider directories will provide. The support will be for the collection of data in terms of querying and retrieving data, and for the disclosure of data in the context of sending out data, not so much in the use part of the data because the provider directory does not get inside the organization to determine how data is used.

But again, that was the original context. But there is the other context that I think Art is bringing up, which is, what about the collection of the provider data for provider directories, the use of provider data for provider directories and the disclosure of that data. That's a different aspect of this principle. That's a different way of applying these principles to a provider directory, I think.

Art Davidson – Public Health Informatics at Denver Public Health – Director
In some states, they intend to use the listing, the Department of Regulatory Affairs where physicians are licensed. In some states, I think they are unable to share that information with other agencies other than the regulatory agency. In other states, they're able to use that as sort of the seed for a provider directory. I think there may be some issues about who collects and who discloses the information in various states.

Walter Suarez – Institute HIPAA/HIT Education & Research – Pres. & CEO
The provider directory information not so much the health information of patients.

Art Davidson – Public Health Informatics at Denver Public Health – Director
That's correct. That's what I'm trying to drive toward.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
This is why it's always good to confirm these principles. I guess, and it feels to me like having these focused on this question of the information that's in the provider directories is the appropriate focus of it. And so getting specific, for example, Walter, I don't know why we would, and didn't notice this before, so I apologize, why "use" wouldn't be in there because certainly if I'm a physician, and my information is going to be in there, presumably we want to – looking at openness and transparency right above it – have a particular provider have some understanding of how the information is going to be used. Is it going to be sold to pharma companies, for example?

Walter Suarez – Institute HIPAA/HIT Education & Research – Pres. & CEO
Yes, so let me explain maybe, and this is the suggestion I would make is imagine if you have a matrix that has the rows, each of these five principles, and in the columns, there are two columns. The first one is provided directory information, and the second one is health information exchange information. In the

first column is how the principles apply to the data content of the provider directory: the collection, use, and disclosure of the data inside the provider directory, the data quality of that data in the provider directory, the safeguards, the accountability.

Then the second column is for each of these principles, how the provider directory supports health information exchange, which is how it's written in, for example, collection, use, and disclosure, data quality, safeguards, accountability. All those descriptions is really on that second column. So we can build it too in fact because we want to make sure that people understand both how the data inside the provider directory is collected, used, disclosed, the integrities insured, the safeguards … but as well as how the provider directory supports the collection, use, and disclosure in the context of an information exchange, the safeguard of the information exchange, the accountability of the information exchange. That will be my suggestion. Now we can refine the description of these principles into those two dimensions.

Art Davidson – Public Health Informatics at Denver Public Health – Director
That sounds good, Walter. Thank you.

Walter Suarez – Institute HIPAA/HIT Education & Research – Pres. & CEO
Yes. I think that's good.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
Are there any other comments and thoughts on the principles? Let me ask, could we advance the slide, please? Here's where we're going to start doing a little work. Now we need to step back. We've gotten, I think, as Jonah said, I think the principles were pretty well received. Now we want to move forward from that to laying out sort of a framework for how we're going to get to a set of recommendations related specifically to this concept of entity directories.

It's kind of laid out a set of steps here, and want to have the taskforce sort of weigh in on that, so this is a proposed framework, as it says, where we want to be able to consider sort of a high level what are kind of different directory requirements, as it were, for any type of entity sort of directories that we may be weighing in on or making recommendations about, and the possible options. Some understanding of that would then hopefully provide the foundation for us to then make a set of recommendations related to sort of what policy issues arise from a set of models that we may be looking at. Then, finally, what set of policy actions then we might recommend related to all of this?

We kind of put this into the category of one whole set of things, which are really about sort of environmental scan and business analysis, just a basic core understanding of what's out there and what the possibilities are, and then consensus, conclusions, and recommendations, which is really about saying given the world as we know it, and as we project it, where, from a policy perspective, do we think we need to weigh in or want to weigh in? We broke that out into a set of key steps. Obviously not all linear, and doesn't mean that we don't shortcut some of it to get to a better understanding. But at the end of the day, we want to have a sense of sort of users and uses. Who is it that wants an entity directory, and what do they want to use it for?

I think, as we've sort of described, and we've described at the Policy Committee, this is really just about being able to do things that will accelerate and improve hopefully the quality and higher speed adoption of health information exchange at the end of the day. But it's not about being able to say that health information exchange will not happen without this. It's not necessary. It's really just about saying, what can we do to make the situation better.

Looking at users and uses, and also taking into account that a lot of organizations and entities have gone forward with their own solutions to this. It's a complicated environment, and there are a lot of directories out there that have already been created for a set of purposes. So it begs the question for those of what could you possibly do that's better than what they already do and that would mean that they would stop

doing what they're doing to do whatever it is that we're proposing? All of that is, I think, buried in there. The second consideration would then be what functions.

Walter Suarez – Institute HIPAA/HIT Education & Research – Pres. & CEO
I was looking at the other ones. I didn't see this, but maybe we can refer to this as participants, users, and uses because one of the questions we need to address is who is going to be participating as in having an entry in this directory. That is a different question than who wants an entity directory and what they want to use it for.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
Yes. I was thinking of that as being a part of content, but I think it's fair. The way we had laid this out sort of as a flow was to say, well, who actually wants to use it and try to separate uses from sources. But if it makes sense to put it over here, I think that's okay.

Walter Suarez – Institute HIPAA/HIT Education & Research – Pres. & CEO
I'm finding it could go under the content, but more in the form of a question, not just what data, but who.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
Yes. Absolutely. That makes sense. It's in here. I think it's just a question of where.

Walter Suarez – Institute HIPAA/HIT Education & Research – Pres. & CEO
Exactly. Yes.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
That's a good point. Then a set of considerations about what functions do the users need for their desired uses? What would an entity directory have to do in order to fulfill the needs of the users and the uses that they want to have? The constant is what information then needs to be in this entity directory concept to enable these functions? That's to Walter's point is about what organizations or people need to be listed in there, and what kind of information on each.

Paul Egerman – Software Entrepreneur
When it says content … what data?

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
Yes.

Paul Egerman – Software Entrepreneur
Are you talking about specific data elements? Are you talking about like categories, types of data?

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
However much detail we think we need to get to.

Paul Egerman – Software Entrepreneur
It would seem to me, from a policy standpoint, we'd want to stay at a high level. We don't want to specify data elements.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
Right. Paul, can I just ask, what would be sort of an example of where we don't want to go?

Paul Egerman – Software Entrepreneur
You might say that the directory has to show what services need to be offered or might be offered by a specific node. I think that's all you have to say. You might define services broadly, but we'd let the Standards Committee figure out, well, gee, that means you've got say what's the specific content standard and the release number. I don't want to go that deep. We can just say services. Or if we get to

the point of the individual clinician directory, we could say contact information without having to specify every single data element. You want to have a phone number or fax number and stuff like that.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
Right.

Walter Suarez – Institute HIPAA/HIT Education & Research – Pres. & CEO
Yes. I think that's a very good point. I agree. I think other examples would be entity type, which we have in the questions that we've formulated for the next steps. We already have some categories of the information listed there: entity type, characteristics of entities, like demographics of entities, but by demographic, I mean contact information or information about the entities that identify the entities, the name of the entity, the address, things like that. But I agree. I think we just want to keep it at a higher level, aggregate types of data ….

Paul Egerman – Software Entrepreneur
Yes ….

Walter Suarez – Institute HIPAA/HIT Education & Research – Pres. & CEO
… Standards Committee ….

Paul Egerman – Software Entrepreneur
Really what types of data, what categories of data. I don't know what the right word is.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
Yes. Again, this is just framework with the idea being that we will have specific conversation on each one of these, but just trying to lay out the roadmap here for the taskforce. Operating requirements, what would be the operating business requirements in order for an entity directory service or an entity directory that we're proposing to be used?

Paul Egerman – Software Entrepreneur
What's the difference between that and functions?

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
Functions are what it would need to do. An operating business requirement would be how would it actually exist as a business or as a service. Is it CMS or is it a single entity? Is it CMS or a central organization, or is it InterNIC, those kinds of things. I mean, not specific about organizations itself, but business that you wrap around the functions or the business of the operating requirements. I don't want to say that we're going to define a business necessarily, but there's a certain set of business sort of wrap around with service levels and what kind of, you know, sort of how you actually are delivering this service to the market, which is separate from what specific functions it is going to perform.

Walter Suarez – Institute HIPAA/HIT Education & Research – Pres. & CEO
To what extent do we get into describing this business model of getting to some of the technical approaches like federated versus centralized or distributed or hybrid? Are those also part of the descriptions that we would? I'm thinking we'd want to describe those possible approaches. In the general context of not getting down to technical architecture, but at least some of these general technical elements of the approaches. Are those also part of the business models that you see there?

George Oestreich – Missouri Medicaid – Deputy Division Dir., Clinical Services
Wouldn't you sort of do that by describing the use cases that you'd want to support?

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
Yes. That's what I would think.

Tim Andrews
I have a question, which is, if I understand correctly, an important objective is to support use by NHIN Direct implementations for stage one meaningful use. If that's incorrect, I think we should make it explicit. If that's correct, there are implications because that has a very specific technical approach.

George Oestreich – Missouri Medicaid – Deputy Division Dir., Clinical Services
It's a good point.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
Tim, is your question, are we focused on filling the gap with NHIN Direct? Is that your question?

Tim Andrews
Yes. Actually more specific, is it an objective of the recommendations that they do support NHIN Direct for stage one meaningful use transactions, because that's' a significant constraint?

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
I thought that where we came to on that was that it should certainly support NHIN Direct, but our focus is not on NHIN Direct.

Jonah Frohlich – HIT at California HHS Agency – Deputy Secretary
To Tim's point, do we want to have one of our use cases be NHIN Direct so that we can make specific recommendations about how these directories can support it?

George Oestreich – Missouri Medicaid – Deputy Division Dir., Clinical Services
Or not.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
Or not. Right, that's an interesting way of looking at it.

Paul Egerman – Software Entrepreneur
I would think so. I think we're going to look at a number of use cases, and NHIN Direct ought to be one of the use cases. We've got to somehow reflect ONC's view of information exchange, which is sort of like agnostic to lots of different models of information exchange, and so we need to see if we can develop something that will work in all those different models.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
As an exchange, what else will then be sort of a use case in this?

Paul Egerman – Software Entrepreneur
Yes. An exchange could be a use case. NHIN Direct could be a use case. Epics Care Everywhere could be a use case. In other words, we could look through several use cases, and our goal should be to have one approach that is a level playing field that everybody could use.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
Does that make sense to everyone?

George Oestreich – Missouri Medicaid – Deputy Division Dir., Clinical Services
It does. I think it continues to make the job a little more difficult.

Paul Egerman – Software Entrepreneur
Well, that's why they pay us the big bucks.

George Oestreich – Missouri Medicaid – Deputy Division Dir., Clinical Services
That's right.

Walter Suarez – Institute HIPAA/HIT Education & Research – Pres. & CEO
I think we should probably, in describing use cases, not spread to wide into have eight, nine different use cases. I think we should try to focus on three or four use cases at the most: one demonstrating how this could support NHIN Direct, one demonstrating how it aligns with NHIN Exchange, and maybe one that demonstrates how this can be used to support exchanges that are neither NHIN Direct nor NHIN Exchange. That could be point-to-point. It could be, I mean, there could be several possible ways to describe that third use case. Maybe we do three and four to describe two possible, non-NHIN Direct, non-NHIN Exchange examples. But I would probably stop at four use cases, otherwise it might become too complex to even try to describe all the possibilities.

George Oestreich – Missouri Medicaid – Deputy Division Dir., Clinical Services
What if instead of using specific use cases, we use the technology by which you could access the data within the registry in a particular use case and do it from that perspective? Then you'd have the NHIN Direct as one that you either could or couldn't use a modified service bureau sort of approach that it could or couldn't, and then … a diagram there so you more take it up a notch over the specific use cases, more of a categorical use case?

Walter Suarez – Institute HIPAA/HIT Education & Research – Pres. & CEO
Yes, I like that. I think it would be helpful to identify what are some of the core elements in the operational model, yes, operating model, I guess, like a registry, as you call it. Then how it could support the various use cases. But then also how there could be, I mean, that's where we could get into the approaches. What are the possible approaches for a registry? There could be a central, a fully federated, a hybrid, those kinds of possible approaches. But I think identifying what are some of the most critical building blocks of the operating approach will be helpful, and then how they relate to these use cases. I think that will be ….

George Oestreich – Missouri Medicaid – Deputy Division Dir., Clinical Services
Fair enough, the got to have. Yes.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
Yes. Makes sense.

George Oestreich – Missouri Medicaid – Deputy Division Dir., Clinical Services
You're probably getting a deeper dive on this slide than you intended, right?

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
No, well, that's okay. I think it certainly helps in clarifying the framework, and I think that's, at the end of the day, we want to make sure the people are feeling comfortable generally with the framework, and we'll keep revising it along the way. But certainly, this is an important slide for us to all have a general level of comfort with, I think.

Just moving ahead then, the idea of business models, and I realize this may be sort of fairly blurry with respect to how do you separate a business model from an operating requirement. But I think the thought there was, for example, and this has come up. What sorts of levers are within scope of what we could recommend. What is sort of the universe here of things that we could recommend or a range of things that we could recommend. Certainly on a previous call, I think it was Carl who had a suggestion of what if CMS was just required to maintain a text file that people would submit three or four key date items then they achieve meaningful use or when they do their first attestation, and that would be maintained by CMS, and could be pulled down as an ASCI file by any prospective entity organization that wanted to use it for whatever purposes, for example.

That would be a very particular business model that says that a recommendation saying CMS should create something like that, and we can get into a question, obviously, of how detailed we'll get in terms of

the standards or the data that they actually would collect, but that could be one sort of business model, as opposed to all the way at the other end of the spectrum, something that is much more about saying that here is, through a set of the creation of a set of standards that speak to sort of standards that are promulgated and certification requirements imposed on EHR vendors that that creates, sort of cordons off a market opportunity that we think then the private sector will step into and fulfill the need here.

George Oestreich – Missouri Medicaid – Deputy Division Dir., Clinical Services
I think very definitely we need to keep in mind the indirect interface with the NLR that at least the data is going to have, if not in fact the framework.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
Yes. Getting to the policy questions, it seems to me that some … probably will have to come to terms with which business models should the government promote, and put that in quotes, but the idea here is that we'll probably have a consideration of a whole set of things that says here's where we think is an appropriate set of things for us to make recommendations on about where the federal or state governments should be intervening, as it were. Then there are a whole set of things that really aren't under the purview. This is kind of Deven's question of what's the it, and David Lansky's question of what's the it, and where does the government sort of weigh in here. Then for each of those that we think are ones that we want to move forward with or that we should have something to say about, there will be policy issues related to those. Then, finally, some recommended policy actions that we will have something to say about.

George Oestreich – Missouri Medicaid – Deputy Division Dir., Clinical Services
That sounds right.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
I think this will be sort of an iterative process, and we may refine this over time, but wanted to at least put something down that helps us walk through in some type of … way, this deliberation, because we've got really three to four weeks ahead of us before we want to be able to get to the Policy Committee. I'll show the timeline in a second on the 19th of November. Do people feel fully comfortable with …?

Jonah Frohlich – HIT at California HHS Agency – Deputy Secretary
One thing that we may want to consider, and this is part of the earlier framework side discussion that we had with the gap analysis that I think Tim Andrews is going to help us with. That part of our recommendations were going to be based on that gap analysis assessment of what exists today and what we feel is needed in order to expedite information exchange. We're now just working that into the framework or for us to implicitly understand that that's going to help us. I think it would be useful.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
Yes. I think that's in here, but we should just call it out very specifically. You could argue that that's a part of the users and uses is who would use it if there wasn't a gap there.

Jonah Frohlich – HIT at California HHS Agency – Deputy Secretary
Right.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
Yes. Absolutely. That's a great point, Jonah. If we feel comfortable enough with this, I would suggest that we move to the next slide. Again, not trying to close off the conversation, but that would translate into a suggested work plan that looks like this. These are meetings that should already be on everyone's calendars except for November 8th, which there was a big gap, as I was looking at the calendar between the Information Exchange Workgroup that we have on November 3rd. Then a taskforce meeting—PDTF is Provider Directory Taskforce—meeting on the 12th. Judy Sparrow is going to help us work on seeing if we can get a meeting for the 8th, which might help us fill in that gap.

The idea would be really using that framework to say today we want to go through the framework and the schedule, hopefully get a consensus on that, start to begin a definition of users and uses, and discussion of functions is probably too far here. When I wrote this, I didn't really look back and look and think about, we probably want to define our core terms here. I think about defining users and uses and the terminology that I had described in the agenda.

Then looking ahead on November 1st, moving step wise through this framework, and again, it may not all happen linearly, but at least as a place for us to start, starting to think about the functions, starting to think about content and operating requirements, and then perhaps getting a briefing on some specific solutions.

This was another comment from Judy Faulkner at the Policy Committee was that we perhaps do a deep dive into one or two solutions that are already out there to get sort of a better understanding of the issues that they've grappled with and the solutions that they've come up with. One possibility to look at a couple of different approaches might be Epic or an EHR vendor. Epic comes to mind because they've got a very specific solution, and NEHEN might be another example. We could certainly look at Axolotl. I'm open to anything, but just trying to get a couple … that might give a range of approaches.

Walter Suarez – Institute HIPAA/HIT Education & Research – Pres. & CEO
I think Maryland's CRSP might be another one. They launch September 30th.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
Yes. I guess what I was hoping for is something that's actually in production and stable.

Steven Stack – St. Joseph Hospital East – Chair, ER Dept
That might be the Axolotl implementation in Maryland, I think, in Nebraska also.

Walter Suarez – Institute HIPAA/HIT Education & Research – Pres. & CEO
Yes. That'll be ….

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
That's another possibility then, and certainly Epic's NEHEN are in production delivering tons of information already, so that's another possibility there.

Claudia Williams – ONC – Acting Director, Office State & Community Programs
Sorry for joining late. I really liked everything in the deck. Just to clarify, we're focusing on entity directories initially in a directed, point-to-point context. Is that right, when we're looking at these examples?

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
Yes.

Claudia Williams – ONC – Acting Director, Office State & Community Programs
NEHEN obviously, and I guess some of those, like Axolotl definitely supports obviously both query and directed, so we'll just have to be sure we're trying to—and possibly their infrastructure is really for both, but make sure we understand what they need in that particulr context.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
Right. That's a great point, Claudia. Again, looking forward to November 3rd, it's really marching through the framework, but one significant thing on there that I'd love some feedback on is actually related. I think George Oestreich, you had just made this point, is having a better understanding of the CMS, whether it's NLR or PCOS or whatever it is. It seems to come up over and over again that, at a minimum, just needs to be aligned with that, if not really looking ahead saying, well, if we think about a world of the NLR plus

ACOs and what's going to happen there, is there a consideration that that is perhaps a seed for an entity level directory or the best possible seed, entity level, national entity level directory.

George Oestreich – Missouri Medicaid – Deputy Division Dir., Clinical Services
Yes. Exactly.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
Though we've had a hearing, someone some CMS spoke specifically about PCOS, but no one from NLR. We didn't have any conversation about that.

George Oestreich – Missouri Medicaid – Deputy Division Dir., Clinical Services
That's really such a developing opportunity. I don't think anyone could give you a very clear ….

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
Right. Yes, and certainly I think that's true. On the other hand, it could be just a significant sort of piece of this puzzle here.

George Oestreich – Missouri Medicaid – Deputy Division Dir., Clinical Services
Yes, it really will, and I think even arguably a direct interface, as you say, a seed to perhaps a more broad-based directory/registry would be an outcome from that.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
Right. Certainly, and I had a side conversation with Carl, who I know is on the phone here, and one of the things we had talked about with this sort of high level thought that he had on a previous call was, wow, isn't that kind of like the NLR.

George Oestreich – Missouri Medicaid – Deputy Division Dir., Clinical Services
Yes.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
So I think bringing those conversations … together seems fairly important.

George Oestreich – Missouri Medicaid – Deputy Division Dir., Clinical Services
We're having discussions in the state in how we can aggregate some of the similar uses that we would have, and I'd hope that as we sort of flush out the technology, that it can be … enough that it can support that, so that we can all move towards a larger game plan, if you will.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
Right. Then just moving ahead, we've got, now November 9th is the Policy Committee. We want to make some recommendations related to entity directories at that meeting. Starting from the 8th through the meeting on the 8th that we're going to schedule, the meeting on the taskforce on the 12th. Then a full workgroup meeting on the 15th, I think we want to start having some gelling around the set of recommendations. Obviously on the 8th, there'll still be sort of at the very high level formative stage, but hopefully using the 12th and the 15th with a lot of work in between those meetings to try to drive to something that we feel comfortable with and that are specific enough to constitute a set of helpful recommendations.

It's pretty aggressive, I think, as all of you will note, so there's a fair amount of work here, which is why we have a number of meetings. We do have the benefit of having support from Tim Andrews, as well as the great ONC support we get. Tim Andrews is a consultant who, I guess you could count him as ONC support since he's being funded through that, through ONC, but we have the benefit of having Tim, who can help us with a whole bunch of this stuff, and who I'm going to turn to next actually.

Claudia Williams – ONC – Acting Director, Office State & Community Programs

The one thought I had, and I'm not sure how best to accomplish this, but I think when we started to get into the policy conversation about governance and uses and who should have access and how to really assure trust, it ends up interfacing in sort of foundational ways with the uses and users like, do you need to validate medical credentials to support this use, for instance? That would be the kind of question. We might want. I think it's okay to keep the policy discussion for later, but we might want to have some sort of policy checkpoint questions at each stage, so we're sure we're defining the things that would meet our policy goals as well. I don't know how best to do that, but I don't know if it's around—I think it's mainly around sort of trust and durability.

Walter Suarez – Institute HIPAA/HIT Education & Research – Pres. & CEO
Let me ask you, Claudia, because the example that you give or gave on the medical credentials is not within the scope of this first part basically. So we've got to be careful not to bring in elements of the next stage, which is the individual person ….

Claudia Williams – ONC – Acting Director, Office State & Community Programs
That's a very good point, well taken, so maybe the meta-question is, what things will enable the thing we're outlining to be trusted in the context of the use case that we're teeing up. I just think we need to iterate the use case and users against some of those bigger questions, as we're developing them so that we don't get to the last stage and say, we haven't defined the thing that's going to work.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
No, I think that's right. I guess the way I would answer that is to say that what we don't want to do is get into one of these things where you're just in an endless loop.

Claudia Williams – ONC – Acting Director, Office State & Community Programs
No, no ….

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
Yes, so I think where I would, even in the framework, say that that specific thing that you just raised, leaving aside whether it's about credentials or whatever, is that that might be an operating requirement. For example, that if you are a user who says I want this function, one of my requirements, if I'm going to have this service be a service that I use, is that it's got a certain degree of sort of a trust foundation. We can try to specify that. Then later we say what policy levers need to be pulled in order to insure that that trust foundation would exist in an operating model.

Claudia Williams – ONC – Acting Director, Office State & Community Programs
I like that.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
Are people fully comfortable with this framework, the work plan? I know it's fairly aggressive. It's obviously more than fairly aggressive. We'll certainly iterate on it and refine it along the way. I'd be shocked if two weeks from now this work plan looks like it does on slide five right now.

George Oestreich – Missouri Medicaid – Deputy Division Dir., Clinical Services
If it wasn't aggressive, it wouldn't fit in with the rest of the process.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
Right.

Claudia Williams – ONC – Acting Director, Office State & Community Programs
We're getting a bad reputation, I think.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
Yes. We specifically tried not to call this a tiger team, but I think we're approaching tiger team.

Claudia Williams – ONC – Acting Director, Office State & Community Programs
Yes. I will point out that Micky had come up with all the schedules.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
Let me just ask Paul Egerman. We're going to get into the entity conversation in a minute. I know there's a huge dependency, I think, in an alignment we want to do with the tiger team, as you're defining entities for authentication. Do you think that this timeline roughly aligns with where the Privacy and Security Tiger Team is going to be?

Paul Egerman – Software Entrepreneur
Yes. We're hoping exactly consistent with the schedule to have our authentication recommendation on the November 19th Policy Committee meeting. The same as you, it's hard to know if we're going to get there because there are a lot of steps. But this is an alignment.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
Right, so I guess the good news and the bad news of that is that we're going to be jointly defining entities over the same timeframe. It would have been great if you defined it, and then we just took it, but I guess we're going to be jointly defining what an entity is in this process.

Paul Egerman – Software Entrepreneur
Yes. That doesn't strike me as a difficult part of the process though.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
Right. Great. I guess we'll see right now. If we could advance the slide please, so I'm going to turn it over to Tim Andrews. The idea here is we want to walk through a particular use case. Tim has drawn up a couple of slides for us here. Not to say that this is the only use case we want to look at, but really as a way for us to define, really as a tool, to define some key terms. Again, there are many possible use cases, but I think that this can be useful in just getting us to what's going to be the last slide here, which is a set of things that we think are key terms that we need to define. Although as a workgroup process, we'll decide whether we've captured the universe of things that we need to define. For those that we've tried to lay out sort of a straw man definition of where we need to possibly change those.

Just so people don't feel like aren't we moving backward? Didn't we have sort of pictures and conversations about this and get a little bit tangled up earlier? What I would say is, we had a lot of conversation, I think, where we started to get very specific about certain things, and I think we collectively stepped back and said, let's think about principles first and then move this sort of more of a step wise process of saying, let's think about principles, and then we're going to stage the way we think about it, but then drill down and dig down into the meat of it. Sorry to mix analogies there.

But now here we are, that we need to now get into the meat of it. So now, to the extent that it feels like we're stepping back, it's really just saying now is the appropriate point for us to get to this level of detail that we need to have a core understanding of, and we don't need to understand every single technical element of information exchange, but there's certainly sort of a lexicon and a taxonomy and a basic understanding we want to have in order to have a coherent conversation and set of recommendations going forward.

Let me turn it over to Tim. We've got 35 minutes here to, I think, walk through this and then come back to sort of the terminology and definitions page, which is at the end, and let's see how far we can get into that.

Tim Andrews
Micky, from a process perspective, do we need to leave time for public comment at the end?

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
Yes. Actually, that's a great point, Tim. Why don't we say we will do this for a half an hour, and that'll leave us some time for any public comments that might be there?

Claudia Williams – ONC – Acting Director, Office State & Community Programs
Can I just ask a sort of—? I think it's one of those chicken and egg things that I keep on thinking about. There's the world of current directed messaging, and then there's the actual direct specs that are teeing up the same questions. I think we're trying to keep both concepts in our heads. Is that right?

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
Yes. Absolutely, and that'll come out, I think. It'll inevitably come out if my conversations with Tim are any indication.

Tim Andrews
Indeed, an excellent point. I'm going to run through this pretty quickly then to try and enable time for discussion, so I guess we'll try and say shoot questions and comments in. Micky, maybe I'll ask you to sort of keep an eye on the time to keep us moving.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
Sure.

Tim Andrews
This is, again, sort of a prototype exercise here, as Micky pointed out. From the earlier discussion today, we're going to have a few, hopefully a relatively small number of use cases, but they need to be clear enough that they get at the intent of what we're trying to accomplish so when we get down to the level of definitions and terms and recommendations, we can relate them to things that are actually happening. That's sort of the idea. I know most people have been through this, but it's important to formalize it and make sure we really do understand what we expect to happen out there in the clinical environment.

I picked the simplest directed exchange, I think the simplest that most people relate to, which is the referral of a patient from a primary care to a specialist. Again, even here, you can start getting into interesting discussions about how it actually happens, but I wanted to … that is, I wanted to extract away all the detailed technology, to Paul Egerman's point, to the greatest extent possible to try and really get at the essence of what we're trying to accomplish and why we're trying to accomplish it. This is just, again, as straightforward as it can be, the idea that we've called, I think, to date, a clinician. Again, we'll get to the terms and definitions, as the person who is interacting with a system, which we've called many things, but I've labeled it at least for starting points and endpoints. Then we have the magic in between. At the other end, we have the specialists.

This is my pretty much idealized view, so again it could be completely challenged at any level. But I think, at the highest level, we're talking. One assumption that I made, for instance, I do have the NHIN Direct model kind of in my hat. I will take the advice and try … out of the picture as much as possible and get to the next level up. This kind of does, but I would say it's more lucky than thoughtful.

You have a PCP within the EHR. There's a whole other discussion about whether you deal with PCPs who don't have some sort of electronic system already. At a point of care, having an encounter, determines that one needs the consult, needs to get the information to a specialist. I wrote as point three here, for instance, type in specialist and then hit send. That's my conversation with providers. That sort of reflects their idea of how it should work. But even there, you could say, in many different ways, that could happen.

Then on the receiving side, again, my experience in the clinical environment is mostly, presuming you have some sort of electronic system, you see that you have an in box or some sort of trigger that says

you have a new message. It's one's record that's come to you for a referral. You have the ability typically to take a look at that and often to keep parts or all of it and integrate it into your fields of information, and you're going to have your encounter, do your diagnosis, enter some notes, maybe take some tests, whatever it is, and ideally, and this is why the e-mail paradigm feels right in many ways, you sort of reply. I got the message. Now I've done my work. Now I'm replying back to the PCP. Again, that's sort of the way specialists will talk about it sometimes … just sending a reply back.

That's sort of the highest level. The idea is to really try and keep the technology out and get to the functional flows from here of what's required to support this and the policy implications thereof. Let me pause there and ask for comments or questions at this level.

George Oestreich – Missouri Medicaid – Deputy Division Dir., Clinical Services
I guess the one thing that I see this as a use case that certainly is a very practical use case, but would we also be considering that this may be at a service level and the directory and the work that we're doing would be at a layer one or two layers up from this with the opportunity to maintain discrete data elements in that that can then be pulled down to this service level so that we've got a broader use case above this, more of an NLR sort of global registry, if you will?

Tim Andrews
I think so, but let me try and reflect what you said and make sure we are actually talking about the same ideas because I'm not quite sure what you meant when you said service level, but I think, if I would put it in my own words, what I hear you saying is there are many use cases, and those use cases will have some things in common, and the union of all of them together would be larger possibly, probably, than any particular use case. That union of all the information could be a higher-level concept of what the provider directory is, so it can service all of these use cases. Is that what you're saying?

George Oestreich – Missouri Medicaid – Deputy Division Dir., Clinical Services
Right. Each of the service or use cases would have analogous data points, data elements, and where they come together, then you have a list of all common elements that are maintained to be authoritative and accurate that everybody can use.

Tim Andrews
Right. Yes. I think that's exactly the idea, and I think it's generally, at least in my experience, easier to work from the concrete. That's why people do use cases because you write down specifically these are each of the things I want to accomplish. Then the next step is to try and abstract up from there what's common across them.

George Oestreich – Missouri Medicaid – Deputy Division Dir., Clinical Services
Right. I'm with you.

Steven Stack – St. Joseph Hospital East – Chair, ER Dept
Tim, I think you've accurately captured the level of sophistication that doctors, nurses, and other health providers are going to bring to the table for this. That's about as complex as they're going to want to get for how does it work.

Tim Andrews
Right, and I think it's important for us to think about that because we will ultimately have to go much lower level in terms of getting to specific, even to some level of technology, even if it's fairly abstract. We just want to keep in mind that this is what we're actually doing. Again, we have to think about what the experiences of these individuals are and how the system supports those experiences. Then when we get to policy recommendations, to try and keep them linked together. It's hard. It's complicated work to do that.

Paul Egerman – Software Entrepreneur

I have a comment on this slide, as it relates to the specialist side. If you look at the PCP side, you have the clinician and an endpoint. On the specialist side, you also need to have an endpoint. In other words ….

Tim Andrews
Right. I didn't put the labels on both sides. There should be a symmetric set of labels on the specialist side.

Paul Egerman – Software Entrepreneur
Because if you read the five points under the specialists, it depends on how you read them. It says see one's record available. I'm not sure what that means because what really happens is whatever transaction that comes from the PCP, let's say it's a CCD, a patient summary, it's got to go to the endpoint. The endpoint has got to do something with it because it's not readable by the specialists in the format it was sent. Once the endpoint does something with it, it actually goes into the record in some format so that ….

Tim Andrews
Actually, at least in my experience, most EHRs don't, well, they sometimes have rules that let you automatically … but most of the time they have some sort of staging area, an inbox kind of thing or a trigger that will give you some sort of alert that you have new information available. Like an inbox might say clinical message inbox might say a message has come from PCP Dr. Allen.

Carl Dvorak – Epic Systems – EVP
I spent some time at the IHE interoperability showcase the last couple of years, but most of them and similar to what we do is they bring it into the chart in an outside records sort of quarantine spot. They signal the providers to a message that it's arrived in the chart. So if anybody brings up the chart, it's there, and it's visible. Then certain vendors will, if you want to click on that, it'll say there's discrete data in here that we may incorporate into your chart. Then that'll let them pick and choose what to bring in that actually adds value to the chart rather than clutters it up or even makes ….

Tim Andrews
Right. Exactly. Yes. Whether it's in the chart or out of the chart in an electronic world is a definition, but it's not part, I guess, of the legal record in some sense, or at least it's not integrated into the normal fields that people use within their EHR without typically some ….

Paul Egerman – Software Entrepreneur
That's the key issue. It may or may not be integrated into the record, but it is part of the legal record. Once the specialist has looked at it ….

Walter Suarez – Institute HIPAA/HIT Education & Research – Pres. & CEO
Not until ….

Paul Egerman – Software Entrepreneur
… accounting for disclosures and liability ….

Claudia Williams – ONC – Acting Director, Office State & Community Programs
I wonder if we should—

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
I agree.

Claudia Williams – ONC – Acting Director, Office State & Community Programs

—focus. There's a lot in here that's reflecting a full spectrum of decisions and technologies. But it feels like where we need to focus our effort is on the addressing and entity piece of it. So a great discussion, but I think a lot of that isn't necessarily critical from the piece that we're charged with dealing with.

Walter Suarez – Institute HIPAA/HIT Education & Research – Pres. & CEO
The part that I miss in this picture was the entity, as I think Claudia is pointing out. I think where it says clinician and endpoint, in between the endpoint and this magician, I suppose, that's in the center, somehow there is an entity level that does the processing of that request or that ….

Tim Andrews
That's correct. That's correct.

Claudia Williams – ONC – Acting Director, Office State & Community Programs
This … my question, I guess, was I think this picture assumes there's a mechanism to link the specific clinician's name to an entity, and I guess I had thought we were saying we're not doing that for this phase because I'm not sure how you'd link Dr. Jones to his entity without having a registry of all the Dr. Jones.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
Right. I think, Tim, maybe we should move forward … slide. I think we're going to get at just ….

Tim Andrews
Yes, I think these are all the right questions. I think these are all the right questions. We're getting into the next level of detail, which I think is good.

Paul Egerman – Software Entrepreneur
The important point that … make before we go onto the next slide is on the specialist side, there has to be another endpoint.

Tim Andrews
Yes, that's right. There should be the same labels on both sides.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
Yes. Absolutely.

Walter Suarez – Institute HIPAA/HIT Education & Research – Pres. & CEO
Then there's another important point, I think, which is in the "hit send" part. I think there is one thing is to tie to specialist name, and another thing is what is the message that is being sent. I mean, if it's a message that is going to include or that is going to package a summary of the patient record, that's one thing. If it's a message that it's just being sent to the specialist saying, I'm going to send you this one for you to take a look at, that's another type of message. I think there is the perception that it's simply just typing a name and then hitting send. But what is the send? What is it that I'm sending is going to be important to also distinguish.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
Right.

Tim Andrews
Agreed. I guess I was partially trying not to go there because, again, as pointed out, we're trying not to worry too much about the end user direct technical stuff, but about how this is going to ultimately transfer between entities because that's what we're concentrating. So I was kind of thinking ahead a little bit.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
Right. Yes. I would move forward, Tim.

Tim Andrews
Why don't we advance the slide then? This is just saying a little bit more precisely the same thing in worded terms, so we should go over this pretty quickly. Again, there are two cases here, I think, but I wanted to verify that, and have us reflect on these use cases to make sure we all are agreeing that there are cases where the PCP knows the specialist. NHIN Direct, in particular, really focuses on that one where you … middle of the specialist.

You may not know the specialist's electronic address, but you definitely have a bona fide relationship with a particular specialist. It was brought up that there are many times where you may not know a specialist in this case. In other words, you may send it to a radiology department or a surgery department. You may get a number of people, and there isn't a particular specialty though, so you have some sort of either group, or you may even have to look up if you're in an IDN or something, who might be the appropriate specialist to send to.

There may be a TPO kind of relationship because of the way the treatment is being organized, but you might not know the person. So you have a sort of different, a slightly varied use case there. It's important because it came up a lot even in the testimony in the provider directory hearing, so you still need to find that address at the end of the day. But there was a lot of discussion about you may feel a little – you want a little more assurance in that case when you don't already really know who you're sending this person to. So that's the only reason I brought that variation out.

Again, welcome to hear comments. This is what we have to do is flush these use cases out and say that's a valid concern or not a valid concern or one that should affect this level of work, or one that we should put off until we get really to talking about clinicians. But it seemed to me that that's one that could affect entity level activities if you need some, and it's one that crosses that boundary. What kind of assurance is enough assurance, and how do you figure that out, and what are the policy implications? That's the kind of thing.

Paul Egerman – Software Entrepreneur
Yes. My reaction to that, this is Paul, is that for the entity level directory, we ought to simply work under the assumption that the entity that the specialist belongs to is known and the selection is made without dealing with how that occurred. That becomes part of what we're going to deal with when we get to the next level of the clinical level directory. We should just assume that, which it's a common use case anyway. The specialist and the specialist entity is known.

Claudia Williams – ONC – Acting Director, Office State & Community Programs
That to me is also at least, I mean, we can question whether that's the right going assumption, but I think that's the assumption we've been working from, so I think it's just a matter of saying PCP knows specialist and entity. I think we should push ourselves on how comfortable. What if you know the entity, but it's a different set of words than what's in the direct? We can still play with how to assure yourself that that's the right entity that you think you know, but I think you have to assume for what we've teed up for phase one that you know the entity, as well as the name of the specialist.

Paul Egerman – Software Entrepreneur
That's right. You know you're going to send the patient to ABC Imaging Organization down the street or Dr. Smith across the hall. That's 80% of your practice, and you do that 80% of the time, and there are a dozen of those groups that you deal with, and you know them.

George Oestreich – Missouri Medicaid – Deputy Division Dir., Clinical Services
There are two things that I'd add. You may know the entity, but you may not know the location of the entity in relationship to the record that you're sending or there may be multiples. Secondly, you may be sending, in the case you've described for an imaging, you may be sending a request for the actual performance of the imaging, but also the reading of the imaging, so it may be one to several. When it

comes back, it may be one to several back to the referring specialist, as well as the referring PCP. I think you're going to have to have that at the base level.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
George, could you clarify?

Claudia Williams – ONC – Acting Director, Office State & Community Programs
Yes. That was really, really deep.

Tim Andrews
Yes. I think what George is saying is that oftentimes what appears to be a simple referral actually has several discrete parts to it. Even something as simple as, go get an MRI on your knee because we think you've torn cartilage, part of your request is you have to schedule and get an MRI at a location thing and physical thing. Part of it is a radiologist has to read the MRI, write a report, and send it. Then sending it also can be a little more complex than just sending it because the referring providers, say an orthopedic, certainly wants to get a copy of that, may even get multiple copies. They often get what's called a wet read, and then they get a full report. Then they want to send a CC, as it's often called, to the other people, to the hospital, to the referring, to the initial referring PCP. Even though it looks like one transaction, when you actually break it out, it turns out to be a few different transactions.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
Right, but in directed exchange, each of those is a transition of care across a legal entity, so each one of those is a separate directed exchange, right?

George Oestreich – Missouri Medicaid – Deputy Division Dir., Clinical Services
I don't think ….

Claudia Williams – ONC – Acting Director, Office State & Community Programs
Right.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
Yes.

Claudia Williams – ONC – Acting Director, Office State & Community Programs
Each … is a separate message, right?

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
Yes. Each is a separate message. George, I wanted to ask you a little bit more about the first comment you had about different locations. If ABC Imaging has ten locations, I happen to go to one location, ABC Imaging is a domain, and so we're just delivering to the domain. They decide how it gets to the particular user who happens to reside in a particular place, right?

George Oestreich – Missouri Medicaid – Deputy Division Dir., Clinical Services
If in fact they are operating in a single domain. In our current system in imaging, prior authorization, you frequently have ABC Imaging operating multiple domains. The first question is, where do you want that patient to go, and where does the patient want to go?

Paul Egerman – Software Entrepreneur
That's right.

Walter Suarez – Institute HIPAA/HIT Education & Research – Pres. & CEO
That actually introduces an interesting aspect, and I think we need to be explicit about, which is the involvement of a health plan in the process. The administrative transaction that exists that occurs is between a provider and a health plan to request and authorization for it where there's some sort of an

exam. It's important to know whether we are going to be looking at that as also part of the exchange that is supported by the provider directory or not. In many cases, the PCP requests an MRI. It doesn't go to an individual within an x-ray lab. It goes to the entity only. There's no specific technician that is supposed to conduct the MRI.

Carl Dvorak – Epic Systems – EVP
… I think one more thing to add to that. For organizations that have the scenario of they actually operate on different physical systems for some reason, they'll have to put forward a set of names that people who wish to send them information could recognize or differentiate among those choices, or they'll have to have one name, and then a splitter themselves. Then, secondarily, some organizations will actually have one system, but be known by ten different names, so they'll have to put in ten entries into some directory, but all might share a common address coming back. That does generally tend to handle that situation reasonably well.

Paul Egerman – Software Entrepreneur
Yes. I agree with what Carl said. I want to backtrack a little bit to a few other comments because when you think about the selection, it's usually the patient participates in the selections. The patient will say, can't you get something closer to where I live?

George Oestreich – Missouri Medicaid – Deputy Division Dir., Clinical Services
Right.

Paul Egerman – Software Entrepreneur
So there'll be sometimes a lot of different reasons. It's also true that in many cases there's some insurance preauthorization required, but I think we can simplify our lives significantly if we just assume that we're going to take this discussion from the point where the decision has been made, and assume that the specialist entity is known. That makes our life a lot easier, and that will allow us to go forward and decide how we're going to do these—organize the directory.

Claudia Williams – ONC – Acting Director, Office State & Community Programs
I just want to suggest a possible process here. I think what we'll try to do, working closely with the chairs, is synthesize the results of each of these discussions in a set of sort of straw man recommendations that we can tee up at the beginning of the next meeting. I do think, given that this is our—we don't have on the books another discussion of uses and users, I wonder if we should move to the next page where there's some additional sort of nuance to consider and spend a few minutes talking about that.

George Oestreich – Missouri Medicaid – Deputy Division Dir., Clinical Services
Claudia, I think you're right from a perspective of time, but I would like to sort of parking lot this because I think if we make it simply easier for us to make a simpler model, we're undermining the usability of it.

Claudia Williams – ONC – Acting Director, Office State & Community Programs
What I heard from this discussion was two things: one that the entity definition has to track to the actual electronic systems. In other words, if I use a different … information system than you do, we have to be able to have two different entities defined for that, but those also need to map back to the humanly recognizable form of that entity. I think that supports what you suggested, which is the need to have a meaningful distinction between entities that get you to the right electronic system. Isn't that what you were saying?

George Oestreich – Missouri Medicaid – Deputy Division Dir., Clinical Services
Yes. I think the discussion that came forward then was the interface of a third entity, the payer entity or the MCO entity that I think is an excellent point that we don't want to ignore.

Walter Suarez – Institute HIPAA/HIT Education & Research – Pres. & CEO

Yes. The other aspect I would say is, I think it's going to be helpful to simplify things by making some assumptions, and we should be explicit about which assumptions we're making. One that I think we should not make is that we know or that the entity, that the PCP knows the entity. I think the assumption could be that the PCP knows the specialist, but there are two possibilities. They know the specialist and know the entity, or they know the specialist and don't know the entity. The purpose of the entity level directory is to help identify the entity and then help route the information to that entity. If the entity is known, the only functional benefit of the directory is, well, it's known, so there's no discoverability of the entity.

George Oestreich – Missouri Medicaid – Deputy Division Dir., Clinical Services
Can I just say, it's fair enough to raise that now, but I think we just agreed earlier in the call that we are going to go with the assumption that the entity and the user and the specialist are known.

Walter Suarez – Institute HIPAA/HIT Education & Research – Pres. & CEO
I thought I heard … the specialist part I agree. I think the assumption of the entity is known, always limits the scope of the functionality to being too narrow. I think we agreed in earlier calls that the three functional aspects of what we were going to focus on were address schema, discoverability of the entity, and discover the entity's credentials. Those are the three things.

Paul Egerman – Software Entrepreneur
Walter, that's right. That's why assuming that the entity is known makes it possible for us to focus on that.

Claudia Williams – ONC – Acting Director, Office State & Community Programs
I think there are a couple ways to address that, I'm wondering, Walter. One is that we have a set of offline tools we use to find entities. We call up the provider. We use the Google, so we're not saying that there isn't a need to … but that we're not resolving that within our four walls. The other is that I think we recognize that there's a desire to link individuals to entities and to find them, but that we would address that in the next phase. I don't know if others agree, but that's kind of the way I'm thinking about this.

Carl Dvorak – Epic Systems – EVP
Claudia, I think I agree with your assessment.

Paul Egerman – Software Entrepreneur
I agree too.

George Oestreich – Missouri Medicaid – Deputy Division Dir., Clinical Services
Perhaps I agree in principle. Perhaps if we do some sort of decision trees on what we are considering as phase one and phase two that we'll kind of keep on target more directly.

Tim Andrews
Can we go to the next slide yet?

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
Yes.

Tim Andrews
We'll go through this slide. I'm going to actually mostly skip this because I think we've had most of this discussion in the last slide. I will say one thing that at least I try and keep in mind is bullet number three, which is, we're making a certain set of assumptions ultimately about how, and I think George used the term, usability or how attractive this is and what the gaps are, why people will use it. We can suggest that, and a lot of the things that we're saying right now, I think we're going to have to consider in that context like the notion that a PCP has to basically know everything.

In other words, how much support does the system, that endpoint system that the PCP or the specialist or whoever it is, is using, has to hide this underlying complexity. It's independent of how we do it. We can set up technologies in many ways, but we have to keep in mind that at least I think what I've heard consistently, this is a big issue. That has significant policy implications if that's the case. We have to draw the line in the sand about what do we think is really going to be required in order to make this usable, and I use that term in air quotes right now, so that providers will be able to adopt it. What are, therefore, the implications of both the EHR and the provider and provider directories that we try and get established. I think the rest of these we pretty much covered.

We will have to decide, I think, as we go through various use cases, whether we want to deal with only EHRs or…. Perhaps, if we're lucky, we can abstract all of that, and it will look the same. But I think, at some point, we're probably not going to be able to just entirely abstract that away.

Paul Egerman – Software Entrepreneur
I don't understand these questions. Are you saying we're going to talk about these later? I just don't understand what's happening with these questions.

Tim Andrews
Partly, yes. I think we're going to have to answer these questions, at least I think, as we go through the process. What does the address look like, and what information it needs? That's sort of pretty much …. Again, we may not want to be specific in terms of data format. But there is, for instance, in this conversation, a very strong assumption, at least abstractly, what the NHIN Direct or e-mail model is, which is, there's a two layer address with a specialist … recipient on the end, and a domain next to it, so there are two pieces of information. It's a two-layer address.

Paul Egerman – Software Entrepreneur
I don't necessarily agree with that, but anyway….

Tim Andrews
I would argue that that is what people have assumed in the discussion even within this conversation. It doesn't have to be an assumption, but it is what people have talked about.

Claudia Williams – ONC – Acting Director, Office State & Community Programs
I think, to distinguish, we're talking about the address, but we could still use the assumption we're getting it to the door of the entity, and the entity is distributing to the right.

Paul Egerman – Software Entrepreneur
That's correct.

Tim Andrews
Correct.

Paul Egerman – Software Entrepreneur
… question about whether or not the PCP has an EHR. I'm trying to understand. Are we supposed to be talking about that now, or we'll be talking about that later …?

Tim Andrews
… talk about it now if we want, but no, I wasn't raising that one now. That was … one that ….

Walter Suarez – Institute HIPAA/HIT Education & Research – Pres. & CEO
I think … vital to the fact that we had a series of assumptions agreed upon today. These kinds of questions become more of a next stage, I think, in many respects. The specialist knows. I think the PCP knows the specialist. We're going down that path, so the referral use case questions would now need to focus on what the functionality of a provider directory where the primary care provider knows the

specialist and the entity. That's my sense. It's really this question. In light of the discussion of the call, these questions became a little bit of into the next round.

Tim Andrews
That's why I said a lot of them we dealt with earlier in the conversation.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
Yes. It may be that we're going to have to do some work in between, offline in between now and the next meeting. I think this set of questions is one that we're probably going to want to engage in. Actually, because I know we're running short on time, if we could jump to the next slide. This has a set of straw man definitions … and some annotations in red, just so all of you know, this was my taking a first stab at them. Actually, not my taking a first stab at them. There was an original slide that I think Jonah and Walter had worked on that I then tweaked. That's in the black, and then Tim Andrews did a little bit of annotation that you'll see as sort of raw comment form in red.

What I would propose is that between now, and we'll send out a reminder e-mail and perhaps a structured way to get feedback on this, that we take a look at these definitions with an eye toward a couple of things. One, does this capture the set of core things that we need to define? Do we have the right set of terms up here? Then, two, for the terms that are here, do those definitions make sense?

Some of the things that occur to me, for example, as we were going through this are entity. Maybe we should just talk about that for a second before we end the meeting and open it up for the public comment period. You could define an entity. I think, Paul, this is where we want to have it very clear and direct connection with the Privacy and Security Tiger Team. But we could define an entity as being a covered entity or business associate, so from a HIPAA perspective, a covered entity or a business associate. There has to be an addressable node on the network, let's say, which would basically say that they have a clinical system that you are able to connect to electronically. I'm just waving my hands at a bunch of specifics there, but if we go with that, even as we have this conversation, public health, I don't believe— Is covered health a covered entity?

Walter Suarez – Institute HIPAA/HIT Education & Research – Pres. & CEO
Not always, only when they are a provider.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
Right. Now we had talked about public health as being a part of our stage one consideration here as a meaningful use stage one focus. Public health would have to be added to that. PHRs, I'm not sure whether they're a HISP. They're clearly not covered entities right now, so not that we're dealing with those in our round one considerations, but we are going to want to have a definition that's expansive. Looking back, we may or may not. Health plans are not included in meaningful use stage one, but they are a covered entity. So I think we're going to probably want to have a separate definition here for what we might call users or whatever are users of the entity level directories that is specific to what it is we're talking about that has multiple overlaps here.

Paul Egerman – Software Entrepreneur
Yes, although you don't necessarily have to deal with this from the standpoint of definition. In other words, you can define an entity. But then you could say, here are the people who are the participants who can have entries in the provider directory, and they could be entities, but they could be, say, public health agencies. In other words, the public health agency may not fulfill your definition of entity, so you simply say they still have an entry though.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
Yes. I agree with that, Paul. I think what probably at some level we want to just make sure that we're clear on the definitions, but you're right. I think just listing what it is we're talking about will make that concrete.

Claudia Williams – ONC – Acting Director, Office State & Community Programs
Micky, I'm sorry. We probably should open for the public comment now.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
Yes.

Judy Sparrow – Office of the National Coordinator – Executive Director
Operator, can you check and see if there's anyone from the public who wishes to make a comment? Micky, I did get some time on November 8th from 2:00 to 3:30 for the provider directory group. I'll send out a calendar invite.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
Are there no public comments?

Coordinator
No, there are no comments at this time.

Claudia Williams – ONC – Acting Director, Office State & Community Programs
Thank you, everyone. We will take a stab working with the chairs to sort of synthesize what we talked about today in a set of preliminary straw man recommendations so that we can sort of address that in the first stage of the next meeting. I'm sad to say I'm wondering if we need two hours for the next meeting, but maybe we can talk offline with the chairs. We also haven't really discussed the comments we got back on the FACA blog posting, so that's another thing we might want to consider for the next call, in addition to what's been teed up.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
Great.

Judy Sparrow – Office of the National Coordinator – Executive Director
Thank you.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
Thank you, everyone. As always, really appreciate it.

Claudia Williams – ONC – Acting Director, Office State & Community Programs
Thank you.